Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov

MEDICAID BULLETIN

Last Updated: 07/29/2022

Screening Prior to Nursing Facility Admission or No Medicaid Reimbursement and Implementation of Verification of Screening- Effective July 1, 2019

This bulletin relates to the longstanding requirement for a Medicaid Long-Term Services and

Supports (LTSS) Screening, (also known as "Screening" or "Preadmission Screening" or "PAS"), prior to the admission of an individual to a certified nursing facility (NF). This bulletin also informs providers of the implementation process that will allow DMAS to verify the completion of screening before Medicaid reimbursement for NF admission and services, effective July 1, 2019.

Clarification of Screening Requirement Prior to Nursing Facility Admission

The Code of Virginia states: § 32.1-330. Preadmission screening required - All individuals who will be eligible for Community or Institutional Long-Term Care Services, as defined in the Virginia State Plan for Medical Assistance, shall be evaluated to determine their need for Nursing Facility Services as defined in that plan. The Department shall require a preadmission screening of all individuals who, at the time of application for admission to a certified Nursing Facility as defined in § 32.1-123, are eligible for medical assistance or will become eligible within 180 days following admission.

Per 12 VAC 30-60-308, prior to an individual's admission to a nursing facility, the nursing facility shall review the completed screening packet to ensure that NF criteria have been met, documented, and submitted via ePAS. Additionally, in accordance with 12VAC30-60-302, an individual's need for LTSS shall meet the established criteria specified in 12VAC30-60-303, before any authorization for reimbursement by Medicaid or its designee is made for LTSS.

In accordance with longstanding policy, neither DMAS nor CCC Plus MCOs will provide reimbursement for nursing facility admission and services unless a valid Screening is completed prior to an individual's admission to a nursing facility. The *Nursing Facility Provider Manual*, Appendix C, Page 8, states that:

"*It is the Nursing Facility's responsibility not to accept residents without pre-authorization who are, or will be, Medicaid-eligible in less than 180 days after Nursing Facility admission…***DMAS will not pay for any period of stay pre-dating the authorization date approved …**"

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Implementation of Verification of Screening Before Medicaid Reimbursement for NF Care Effective July 1, 2019, DMAS will implement a process to verify all new NF enrollments to ensure that a valid screening exists for the individual being admitted. In accordance with longstanding policy, enrollment and Medicaid reimbursement will only be permitted after verification of a completed screening entered into the electronic preadmission screening (ePAS) system (or approved alternative) by an approved screening entity. If a valid screening is not completed prior to an individual's admission to a certified NF, DMAS will not provide Medicaid reimbursement for the NF admission and services.

Additionally, the submission of NF enrollment forms, via FAX, will no longer be accepted or processed by DMAS, effective July 1, 2019.

Special Circumstances

NF providers and CCC Plus Health Plans enrolling individuals into NF care on or after July 1, 2019 without a screening must assure that the individual meets one of the special circumstances (12VAC30-60-302) listed below. DMAS' electronic systems will recognize these special circumstances and will permit submission for enrollment into a NF without a screening, if one of the following applies:

1. Private pay individuals who will not become financially eligible for Medicaid within six months from admission to a Virginia nursing facility.
2. Individuals who reside out-of-state and seek direct admission to a Virginia nursing facility.
3. Individuals who are inpatients in an out-of-state hospital, in-state or out-of-state veteran's hospital, or in-state or out-of-state military hospital and seek direct admission to a Virginia nursing facility.
4. Individuals who are patients or residents of a state owned/operated facility that is licensed by Department of Behavioral Health and Developmental Services (DBHDS) and seek direct admission to a Virginia NF.
5. A screening shall not be required for enrollment in Medicaid hospice services as set out in 12 VAC 30-50-270.
6. Wilson Workforce Rehabilitation Center (WWRC) staff shall perform screenings of the WWRC clients.

NF providers and CCC Plus Health Plans must have documentation to support meeting one of the special circumstances outlined above within the medical record for the individual. Failure to maintain appropriate documentation may result in a retraction of funds reimbursed by DMAS.

Forthcoming Update to the Screening Manual for LTSS- Chapter IV

DMAS is in the process of issuing revisions to Chapter IV of the *Screening* Provider Manual for LTSS. The revised manual will be posted by May 1, 2019. The manual revisions include

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the following:

1. Updates from the new and revised Medicaid LTSS Screening regulations promulgated in the Virginia Administrative Code, 12VAC30-60-301 through 12VAC30-60-315 (*Please refer to the September 26, 2018 Medicaid Memo for more information*);
2. Updates to current language used related to screening and screening practices;
3. Clarification regarding the validity of screening timeframes;
4. Clarification of the requirement for screening prior to admission to a NF and before Medicaid reimbursement;
5. Clarification of special circumstances under which a screening is not required;
6. Identification of required training and competency testing for all Screeners, effective July 1, 2019; and
7. Inclusion of worksheets for evaluating needs for services and supports.

For additional questions, please email Brenda Hornsby, Senior Policy Analyst, at Brenda.Hornsby@dmas.virginia.gov. General questions concerning the screening process may be submitted to screeningassistance@dmas.virginia.gov.
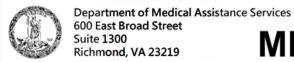
Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as "MEDICAID EXP." If the individual is enrolled in managed care, the "MEDICAID EXP" segment will be shown as well as the managed care segment, "MED4" (Medallion 4.0), or "CCCP" (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES	
Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-forservice members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	

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CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627